FILED
SEP 18 2017
OFFICE OF THE CLERK
SUPREME COURT, U.S.

Nos. 16-1436 and 16-1540

IN THE

Supreme Court of the United States

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL., PETITIONERS
v.
INTERNATIONAL REFUGEE ASSISTANCE PROJECT, ET AL., RESPONDENTS.

DONALD J. TRUMP, PRESIDENT OF THE UNITED STATES, ET AL., PETITIONERS
v.
STATE OF HAWAI'I, ET AL., RESPONDENTS.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE FOURTH AND NINTH CIRCUITS

BRIEF OF AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICUS CURIAE*[1]

The American Professional Society on the Abuse of Children ("APSAC") is the leading national organization for professionals serving children and families affected by child maltreatment, including abuse and neglect. A multidisciplinary group, APSAC achieves its mission through expert training and educational activities, policy leadership and collaboration, and consultation emphasizing principles that are both theoretically sound and evidence-based.

For 30 years, APSAC has played a central role in developing guidelines that address child maltreatment. It is qualified to inform the Court about the damage maltreatment can inflict on children's brain development and cognitive ability. APSAC submits this brief to assist the Court in understanding the impact of Executive Order 13,780 on the physical, emotional, and mental development of children, both those receiving its message of religious discrimination in the United States and those abroad suffering the consequences of exclusion from this country.

APSAC members have a direct and substantial interest in these issues because of their historical and scientific experience with juvenile brain development,

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[1] No counsel for a party authored this brief in whole or in part, nor did any person or entity, other than *amicus* and its counsel, make a monetary contribution to the preparation or submission of this brief. The Petitioners in these consolidated cases have filed a blanket letter of consent. Consent from the respective Respondents has been lodged with the Clerk's office.

especially where child maltreatment is involved. APSAC is therefore qualified to advise the Court on the impact of maltreatment on child health, well-being, and ability to survive.

SUMMARY OF ARGUMENT

Executive Order 13,780 effectuates a discriminatory intolerance of Muslims. The respondents and various *amici curiae* in Nos. 16-1436 and 16-1540 have documented the purposes and motivation of the Executive Order, and they have explained how the Order communicates animus towards Muslims. *Amicus curiae* APSAC submits this brief to draw to the Court's attention the effect of that animus on a particularly vulnerable group of people: children.

Child health experts have found that exposure to early adversity and traumatic experiences can affect mental and physical health and well-being for a lifetime. A clear dose-response relationship between trauma and its health impacts means that the longer children are exposed to negative experiences, the greater the ultimate harm to their brains and bodies.

Amicus discusses two groups of children. Muslim children in the United States suffer fear and insecurity from their government's expression of discriminatory animus directed at them because of their religion. Many also experience physical violence from individuals encouraged by the President's Executive Order. Research suggests that such negative childhood experiences are associated with an increased risk for later depression and other mental illnesses, cardiovascular disease, and other health effects later in life.

Muslim children in the six nations targeted by the Order face acute risk of harm from trauma caused by

violence, malnutrition, displacement, and the constant fear and uncertainty that accompany them. Thousands of children from these countries who would otherwise seek refuge in the United States will instead stay in refugee camps, experiencing additional months of trauma. That time is significant in the lives of these children and will cause additional harm to their long-term health and well-being.

For these reasons, APSAC urges this Court to affirm the decisions of the courts of appeal below.

I. STRESS AND TRAUMA EXPERIENCED DURING CHILDHOOD CAN CAUSE LONG-LASTING PHYSIOLOGICAL AND PSYCHOLOGICAL HARM

Children are not simply small adults. They are, even in their teenage years, in a constant process of development—physically, mentally, and emotionally. A developing child's exposure to environmental toxins, it is well known, can cause long-lasting adverse health consequences. The same is true of exposure to environmental harm that is social, not chemical. The experiences that people have as children help shape their personalities and health, both as children and into their futures as adults. Traumatic and stressful experiences produce genuine physiological changes, which ultimately cause physical and mental problems that can persist throughout the life of a person exposed to adverse experiences during childhood.

The occurrence of these phenomena has been repeatedly documented over several decades,[2] and scientists now widely accept that childhood experiences

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[2] *See* M. Bucci et al., "Toxic Stress in Children and Adolescents," 63 *Advances in Pediatrics* 403, 406 (2016) (discussing a

of trauma and toxic stress correlate to long-term health effects, including adulthood disorders and diseases. Health outcomes that have been correlated with childhood trauma include, among others, substance abuse, mental illness, sexually transmitted infections, cardiovascular illness, cancer, immune disorders, and other chronic diseases.[3] As the American Academy of Pediatrics noted, in response to the Executive Order, "fear and stress, particularly prolonged exposure to serious stress—known as toxic stress—can harm the developing brain and negatively impact short- and long-term health."[4] The damage to physical and mental health and well-being can be severe.

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seminal 1998 study on the correlation between adverse childhood experiences and long-term health outcomes); K. Hughes et al., "The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis," 2 *Lancet Pub. Health* e356, e356 (2017) (noting mental, emotional, and physical health impacts, as "individuals who have ACEs can be more susceptible to disease development through both differences in physiological development and adoption and persistence of health-damaging behaviours").

[3] *See* R. Wade Jr. et al., "Household and community-level Adverse Childhood Experiences and adult health outcomes in a diverse urban population," 52 *Child Abuse & Neglect* 135, 140 (2016); J.P. Andersen & J. Blosnich, "Disparities in Adverse Childhood Experiences among Sexual Minority and Heterosexual Adults: Results from a Multi-State Probability-Based Sample," 8 *PLOS ONE* 1, 2 (2013).

[4] F. Stein, *AAP Statement on Revised Immigrant and Refugee Travel Ban Executive Order*, Am. Acad. of Pediatrics (Mar. 6, 2017), at https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Statement-on-Revised-Immigrant-and-Refugee-Travel-Ban-Executive-Order.aspx.

A. The Developing Brain Responds to Positive and Negative Stimuli and Signals

Research has now begun to reveal the causative mechanisms for the relationship between childhood trauma and adverse health effects.

The brains of infants and children are highly plastic. Developing brains respond to the environment, as neurons "change in response to external signals."[5]

Under normal circumstances, a child's environment includes caregivers, secure sources of physical needs such as food and shelter, and social and emotional supports. Healthy brain development takes place in such contexts, as the interaction between children and their environments provides appropriate external stimuli and generates healthy physiological conditions. But when an infant or child is maltreated or placed in chronic danger, the brain "will adapt to a negative environment just as readily as it will adapt to a positive one."[6] Such adaptations "can cause permanent, life-long neurological damage and have a significant negative impact on the developing brain."[7] Just as exposure to positive environments benefits the

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[5] B.D. Perry et al., "Childhood Trauma, the Neurobiology of Adaptation, and 'Use-dependent' Development of the Brain: How 'States' Become 'Traits,' " 16(4) *Infant Mental Health J.* 271, 274 (1995).

[6] U.S. Dep't of Health & Human Servs., Child Welfare Info. Gateway, *Understanding the Effects of Maltreatment on Brain Development* 4 (2015), http://www.childwelfare.gov/pubPDFs/brain_development.pdf.

[7] H.R. Cellini, "Child Abuse, Neglect, and Delinquency: The Neurological Link," 55 *Juv. & Fam. Ct. J.* 1, 10 (Sept. 2004).

developing brain, exposure to negative or harmful experiences can damage it.[8]

A key mechanism for this damage is the physiological manifestation of stress.[9] In ordinary speech stress refers to external pressures—physical, such as hunger or cold, or social, such as a looming deadline—and to the mental and emotional experience of being under such pressures. But stress is also a physical condition. A person experiencing stress in the colloquial sense undergoes changes in hormone levels and other physiological signals. The hypothalamic-adrenal-pituitary axis of endocrine glands "releases a surge of stress hormones, including adrenaline and cortisol."[10] Additional physiological chemicals may increase in response to stress, including "catecholamine secretion" and "corticotropin releasing factor."[11] These changes cause further metabolic shifts, in physiological substances such as catecholamine and corticotropin releasing factor,[12] as part of an adaptive mechanism by which humans, like other organisms, manage difficult conditions.

Repeated stress, and especially persistent stress, can be toxic, especially in children. Physiological stress response mechanisms become dysregulated, resulting in long-term shifts in metabolism that affect

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[8] Inst. of Med. & Nat'l Research Council, *New Directions in Child Abuse and Neglect Research* 119 (2014).

[9] N.B. Harris, "The Chronic Stress of Poverty: Toxic to Children," *The Shriver Report* 4 (Nov. 21, 2016).

[10] *Id.*

[11] Andersen & Blosnich, *supra* n.3, at 2.

[12] *Id.*

every bodily system, including the brain. The brain continues to develop throughout childhood and early adulthood, and a persistent toxic stress metabolism harms the developing brain. As a whole, "a maladaptive response to stress during childhood, referred to as a toxic stress response, plays an important role in the pathway from early adversity to disease."[13] "Neurobiological changes and disruptions in core stress response physiology . . . have all been linked with childhood maltreatment and are likely central mechanisms by which immune dysregulation, cardiovascular disease, cancer and other chronic diseases are linked" to adverse childhood experiences.[14]

In short, the impact of child maltreatment is neurological and biological as well as psychological. Severe maltreatment and complex trauma can, and often do, cause temporary or permanent physical brain damage as the child's brain molds to fit its dangerous and frightening environment.

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[13] Bucci et al., *supra* n.2, at 404; *see also id.* at 414 ("The toxic stress response is particularly concerning for children because the developing brain is highly plastic and influenced by the environment. The dysregulation of the stress response produces significant biological alterations that can damage brain architecture and impact the nervous, endocrine, and immune systems. . . . Prolonged or frequent activation of the stress response in early childhood reduces neuronal connections in important areas of the CNS [central nervous system] that are key mediators and regulators of the SAM [sympatho-adrenomedullary] and HPA [hypothalamic-pituitary-adrenal] axes.").

[14] Andersen & Blosnich, *supra* n.11, at 2.

B. There Is a Dose-Response Relationship Between the Length and Intensity of Negative Experiences and the Severity of Poor Adult Health

The phenomena described above are not simply on-off, with a child exposed to a negative environment doomed to a lifetime of poor health. Recent research has demonstrated that there is a dose-response relationship between adverse childhood experiences (commonly called "ACEs") and other traumas and subsequent adverse health outcomes. In other words, the longer and more severe the adverse experiences, the greater and more serious the negative health consequences.

With respect to acute physical traumatic events, like abuse or violence, multiple exposures have a "cumulative effect"; "higher rates of trauma are often associated with higher rates of PTSD, depression, and behavior problems[.]"[15] Research indicates that "[t]he 'dose-response' relationship" between the number of traumatic events and adverse health outcomes is "strong and graded."[16] Thus, while a single event can have some long-term consequences, continued trauma leads to progressively worse health outcomes. This is true whether the trauma continues as a "repetition of similar stresses" such as ongoing interactions with an

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[15] Am. Psychol. Ass'n, *Resilience & Recovery After War: Refugee Children and Families in the United States* 26 (2010) (citing studies).

[16] R.F. Anda et al., "The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology," 256 *Eur. Arch. Psychiatry Clin. Neurosci.* 174, 182 (2006).

abusive parent or an "accumulation of disparate ones" such as the succession of adverse events a refugee child might experience.[17] In the case of the refugee children at issue here, "[h]igher rates of trauma appear to have a 'dose effect' in war-affected children: more frequent and severe trauma exposure leads to self-reports of worse psychological outcome."[18]

The trauma and stress of experiencing discrimination has also been linked in a dose-response relationship with long-term poor health outcomes. Research in this area has been sparser, and consequently the effects are less well-established. Still, "[t]hose who are chronically bullied by peers . . . compared to those bullied at one time point have been reported to have a higher risk for adverse outcomes such as psychiatric problems in childhood,"[19] and having inferior social relations in adulthood.[20] There is also evidence for a dose-response relationship between discrimination and poor health outcomes.[21] For example, women who experienced discrimination in three or

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[17] Am. Acad. of Pediatrics, *Adverse Childhood Experiences and the Lifelong Consequences of Trauma* 3 (2014) ("*AAP Statement on Trauma*").

[18] E.E. Werner, "Children and war: Risk, resilience, and recovery," 24 *Development and Psychopathology* 553, 553 (2012).

[19] D. Wolke et al., "Impact of Bullying in Childhood on Adult Health, Wealth, Crime and Social Outcomes," 24 *Psychol. Sci.* 1958, at 2 (2013) (author manuscript).

[20] *Id.* at 7.

[21] N. Priest et al., "A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people," 30 *Social Sci. & Medicine* 1, 10 (2012).

more domains (such as in getting a job or in shopping at a store) had much higher risk than others of having children with very low birth weight.[22] One of the larger studies in this area observed a dose-response relationship between adverse childhood events like experiencing bullying or discrimination and long-term adverse outcomes such as depression.[23] For males in particular, increases in the number of adverse childhood experiences correlate with the risk of later committing violent acts.[24]

The implications of these dose-response relationships are positive as well as negative. While the research shows that longer or more severe exposure to harmful environments leads to worse health problems, it also follows that reducing such exposure can help mitigate the long-term impacts. A child who has experienced trauma will likely suffer some long-term consequences, but improving the child's environment will be beneficial to his or her lifelong health.[25]

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[22] L.M. Pachter & C.G. Coll, "Racism and Child Health: A Review of the Literature and Future Directions," 30 *J. Dev. Behav. Pediatr.* 255, at 5 (2009) (author manuscript).

[23] Wade et al., *supra* n.3, at 140.

[24] J.A. Reavis et al., "Adverse Childhood Experiences and Adult Criminality: How Long Must We Live before We Possess Our Own Lives?", 17 *Perm. J.* 44, 45 (2013).

[25] Bucci et al., *supra* n.2, at 420 ("Recent research demonstrates that even after epigenetic modifications, it may still be possible to reverse negative changes and restore normal physiologic function through positive interactions between child and caregiver.").

II. THE GOVERNMENT'S SANCTION OF ANTI-MUSLIM ANIMUS HARMS AMERICAN CHILDREN

Discrimination can generate significant toxic stress. When individuals, and especially children, experience discrimination or suffer violence or the threat of violence because of membership in a particular group, they can experience toxic stress, which can produce adverse effects through the mechanisms described above.

Anti-Muslim discrimination in the United States has increased significantly in recent years. Physical assaults, attacks on mosques, and hate crimes tabulated by the Federal Bureau of Investigation in 2015 totaled 257, a 67% increase since 2014.[26] The Southern Poverty Law Center has reported that the number of hate groups targeting Muslims jumped from 34 in 2015 to 101 in 2016.[27]

Executive Order 13,780, as the parties and *amici* before the Court have demonstrated, is an expression of animus. Individual actors perceive expressions like this as validating negative conduct towards Muslims.[28] The direct effects of the Order should also not

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[26] Am. Psychol. Ass'n, "Islamophobia," 48(4) *Monitor on Psychol.* 34 (2017) ("*APA on Islamophobia*"). Tables and data accessible at the Federal Bureau of Investigation's Uniform Crime Reporting site, https://ucr.fbi.gov/hate-crime/2015.

[27] Southern Poverty Law Ctr., *Anti-Muslim*, https://www.splcenter.org/fighting-hate/extremist-files/ideology/anti-muslim.

[28] *See APA on Islamophobia*, at 2 (citing K.L. Nadal et al., "A Qualitative Approach to Intersectional Microaggressions: Understanding Influences of Race, Ethnicity, Gender, Sexuality, and Religion," 2 *Qualitative Psychol.* 147 (2015)).

be underestimated. When American Muslims are stereotyped as terrorists, violent criminals, and not "real" Americans, they must maintain a constant state of fear and vigilance.[29] The declarations of the plaintiffs in No. 16-1536 vividly illustrate this experience. For example, plaintiff Meteab reports how people stare at him and his wife and refuse to grant them ordinary courtesies, and they feel isolated and stressed. J.A. 446-447. An expression of animus directly from the national government can only intensify that stress.[30]

The result is a constellation of harms for American Muslim children: they witness rhetoric directed against their religion and community; the rhetoric is coming from their government, a putative source of safety and protection for them; the rhetoric influences non-Muslim children, leading to an increase in bullying; and their parents are stressed and anxious, which can affect the parent-child relationship.

Expressions of animus are not just words to those whom they target; they have real psychological and physiological effects. Studies in this area have typically focused on racial discrimination, rather than religious discrimination, presumably because racial discrimination has historically been more widespread and more readily observable in the United States. Re-

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[29] *Id.*

[30] *See, e.g.*, J. Desmond-Harris, " 'Crying is an everyday thing': life after Trump's 'Muslim ban' at a majority-immigrant school," *Vox* (Feb. 16, 2017), at https://www.vox.com/identities/2017/2/16/14584228/muslim-ban-trump-immigration-ban-children-kids-schools-anxiety.

cent research confirms that "experiencing discrimination is associated with higher reported stress and poorer reported health."[31] There is a "clear relationship between discrimination and increased risk of mental disorders," controlling for other sources of stress.[32] These studies involved adult experiences of discrimination, but the more limited research on the impact of discrimination on children strongly suggests the same result.[33] Experience of discrimination during childhood appears to be a source of traumatic stress, and negative health outcomes result in just the manner described above.[34] Repeated encounters with neg-

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[31] Am. Psychol. Ass'n, *Stress in America: The Impact of Discrimination* 8 (2016).

[32] Article, "Unhealthy Treatment," *UCLA Sch. of Pub. Health Mag.*, Autumn/Winter 2015, at 8, 9 (citing G.C. Gee et al., "The association between self-reported racial discrimination and 12-month DSM-IV mental disorders among Asian Americans nationwide," 64 *Social Sci. & Medicine* 1984 (2007)).

[33] For a review of relevant research, see Pachter & Coll, *supra* n.22, at 255. *See also* Am. Acad. of Pediatrics News, *Study finds exposure to racism harms children's health* (May 4, 2017) (describing preliminary results of new research study). As Pachter and Coll note, research on the impact of discrimination on child health is a new and emerging area of study, but the available research strongly indicates negative health impacts.

[34] *See, e.g.*, M. Jernigan & J. H. Daniel, "Racial Trauma in the Lives of Black Children and Adolescents: Challenges and Clinical Implications," 4 *J. Child & Adolescent Trauma* 123, 130 (2011) ("The implications of perceived racial and ethnic discrimination . . . are overwhelmingly associated with negative mental health outcomes such as depression, stress, anxiety, and psychological distress."); P. Cronholm et al., "Adverse Childhood Experiences: Expanding the Concept of Adversity," 49(3) *Am. J. Pre-*

ative portrayals of their race can cause children to experience toxic and chronic stress, particularly where such encounters make them feel less safe at school or in the outside world. Over time, toxic stress exerts a pernicious influence over mental and physical health, leading to greater risk of depression, suicide attempts, substance abuse, and a host of other ills.

While, as noted, these studies involved race-based discrimination, *amicus* submits its considered view that religious discrimination will have comparable effects. A child experiencing religious discrimination is likely to undergo the same sort of physiological stress response, with similar toxic consequences. And in the case of Muslim Americans, religion is often a proxy for racial identity.

Bullying is a form of discrimination that is highly harmful to American Muslim children. In 2014, according to one survey, 55% of Muslim students in California had experienced bullying in school and 52% had been verbally insulted or abused on the basis of religion.[35] Among Muslim students of Middle Eastern ethnic identity, 64% experienced bullying and 21% experienced discrimination at the hands of a teacher or school administrator.[36] A 2017 survey revealed that Muslim American children are four times as likely to

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ventive Medicine 354, 358 (2015) ("[S]tudies from different contexts have shown that witnessing or experiencing . . . discrimination is associated with concurrent negative health effects and increased participation in risk behaviors.").

[35] Council on Am.-Islamic Rel., *Mislabeled: The Impact of School Bullying and Discrimination on California Muslim Students* 12-13 (2015).

[36] *Id.* at 17.

report bullying as the general public. Worse, one in four of these events involves a teacher or other school employee, indicating that discriminatory rhetoric influences adults to take action against children in their care.[37]

In sum, the approximately 1.6 million Muslim children in the United States are regularly exposed to stress from discrimination and animus, which not only hurts them emotionally but may cause durable, long-term harm. Executive Order 13,780 contributes to and exacerbates this damage.

III. Children in Countries Affected by the Executive Order Face Continuing Stress and Trauma

In addition to hurting Muslim children in the United States, Executive Order 13,780 harms Muslim children outside the country by blocking entry from six countries where the vast majority of the population is Muslim. These children may have varying legal status with respect to the United States; some are relatives trying to join families in this country, while others are refugees who would seek asylum here. As an association of physicians and mental health professionals, *amicus* believes it is important for the Court to be aware of the health consequences of the Order for these children, regardless of their precise legal status. The Executive Order would expose thousands of

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[37] D. Mogahed & Y. Chouhoud, Inst. for Soc. Pol'y and Understanding, *American Muslim Poll 2017: Muslims at the Crossroads* 12-13 (2017).

children in these countries to continued trauma, causing additional long-term physical, mental, and emotional harm.

The trauma is especially damaging to children. Due to their developmental stage, children are uniquely vulnerable to damage from trauma that is highly impactful and difficult to heal. Children are "more vulnerable than adults to the traumatic events, chaos, and disruptions experienced in disasters," and the results can be "serious and persistent even for preschool children."[38] Worse, the stresses of war and political violence tend to co-occur with "forced displacement; traumatic loss; bereavement or separation; exposure to community violence; and exposure to domestic violence."[39] These combined traumas compound the damage done to children in the midst of key developmental stages in their neurobiology. *Amicus* emphasizes that the children that the Order specifically excludes are among the most vulnerable children in the world.

A. The Order Affects Large Numbers of Refugees and Refugee Children

The current refugee crisis bears especially heavily upon the young. Children make up a sizeable proportion of those affected by disaster; "civilians comprise

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[38] R. Williams, "The psychosocial consequences for children of mass violence, terrorism and disasters," 19.3 *Int'l Rev. Psychiatry* 263, 264 (2007).

[39] T.S. Betancourt et al., "Trauma History and Psychopathology in War-Affected Refugee Children Referred for Trauma-Related Mental Health Services in the United States," 25.6 *Traumatic Stress* 682, 682 (2012).

80 to 90% of all who die or are injured in conflicts – mostly children and their mothers."[40] Nearly half of the casualties in today's violent civil wars are children.[41] And fifty percent of the world's 10.7 million refugees in 2013 were below the age of 18.[42]

The countries that Executive Order 13,780 targets—Libya, Sudan, Somalia, Syria, Yemen, and Iran—include some of the most unstable countries in the world, and are the sources of some of the largest flows of refugees in modern history. In 2015, 37% of refugees worldwide came from Syria and Somalia.[43] Sudan accounted for more than 600,000 refugees, and in Libya and Yemen almost 3 million people are displaced internally.[44]

Syria is suffering the worst humanitarian crisis since World War II due to a brutal civil war that began with a military crackdown on antigovernment protests in March 2011. For six years, President Bashar al-Assad's government, a variety of rebel forces, and the Islamic State have mired the country in a conflict that has killed nearly half a million people. Over 13 million people are affected within Syria, 6 million of

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[40] Williams, *supra* n.38, at 266.

[41] Werner, *supra* n.18, at 553.

[42] I. Kaplan et al., "Cognitive Assessment of Refugee Children: Effects of Trauma and New Language Acquisition, 53.1 *Transcultural Psychiatry* 81, 82 (2016).

[43] United Nations High Comm'r for Refugees, *Global Trends: Forced Displacement in 2015* 3 (2015) ("*UNHCR 2015 Report*"), http://www.unhcr.org/statistics/unhcrstats/576408cd7/unhcr-global-trends-2015.html.

[44] *Id.* at 62-65 (annex tab. 2).

them children. Five million Syrians have fled the country and registered as refugees.[45] ***Half of Syria's refugees are children, and more than a third are under the age of twelve.***[46]

In Iran, human rights violations have not improved significantly under President Hassan Rouhani. Under Iranian law, many nonviolent crimes, such as "insulting the Prophet," same-sex relations and adultery remain punishable by death.[47]

Iranian children are also subject to similar human rights violations. Indeed, flogging remains a lawful punishment for children, and LGBTQ Iranian youth have been subjected to electric shocks to "cure" them.[48] The age of marriage for girls in Iran is thirteen, and sexual intercourse with girls as young as nine remains legal. Children also continue to be legally executed by the state. In 2016 alone, at least forty-nine inmates on death row were convicted of crimes that they committed when they were under

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[45] *See* United Nations Children's Fund, *Syria Crisis Situation Report* (Feb. 2017), available via UNHCR Syria Regional Refugee Response Inter-agency Information Sharing Portal, data.unhcr.org/syrianrefugees/regional.php#_ga=1.54009320.1956903019.1492444710.

[46] United Nations High Comm'r for Refugees, Syria Regional Refugee Response Inter-agency Information Sharing Portal, data.unhcr.org/syrianrefugees/regional.php.

[47] Hum. Rights Watch, *World Report* 334 (2017) ("*HRW 2017 Report*"), at https://www.hrw.org/sites/default/files/world_report_download/wr2017-web.pdf.

[48] *Id.* at 335.

eighteen.[49] Violations such as these have contributed to almost 85,000 refugees' fleeing Iran as of 2015; and over 57,000 refugees have sought asylum as of 2015.[50]

Government instability in Libya has resulted in a bloody power struggle that has displaced nearly half a million civilians and has led 6,000 refugees to flee the country since the start of the crisis in 2011.[51] Many have been displaced since the start of the crisis and face a limited ability to return.[52] Moreover, the civilian population that remains in Libya struggles to gain access to basic services such as healthcare, fuel, and electricity.[53] Human Rights Watch reports that in 2016, dozens of rival militia groups and military forces continued to indiscriminately bomb civilians and abduct, forcibly disappear, torture, and unlawfully kill individuals and seize their property.[54]

Libya also serves as an important transit country for migrants trying to reach Europe. Indeed, as of September 2016, an estimated 256,000 migrants have been identified in Libya, of which 23,102 are children, with a third of this group consisting of unaccompanied children.[55]

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[49] *Id.*

[50] *UNHCR 2015 Report*, at 63.

[51] *Id.*

[52] Int'l Org. for Migration, *IOM Libya Brief*, www.iom.int/countries/libya (last updated Sept. 2016).

[53] *HRW 2017 Report*, at 405.

[54] *Id.* at 403.

[55] United Nations Children's Fund Press Release, *A Deadly Journey For Children, The Central Mediterranean Migration*

With respect to Somalia, in 2015, the number of refugees and internally displaced persons together reached over two million.[56] Al-Shabab continues to target civilians and civilian structures, including schools, hotels, and restaurants.[57] Humanitarian agencies struggle to reach needy and displaced populations because of security risks, restrictions, and targeted attacks.

The UN Refugee Agency reports that as of 2015, there are over 1.4 million refugees from Sudan and South Sudan, and over 5 million internally displaced persons.[58] Mercy Corps reports six out of ten South Sudanese refugees are children.[59] Despite continued human rights violations, countries including Italy, Jordan, and Egypt, have been deporting Sudanese back to Sudan, sometimes without assessing their claims to asylum.[60]

Sudan is of particular concern because its refugee camps harbor thousands of unaccompanied minor

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Route (Feb. 28, 2017), https://www.unicef.org/media/media_94941.html.

[56] *UNHCR 2015 Report*, at 64.

[57] *HRW 2017* Report, at 537.

[58] *UNHCR 2015 Report*, at 64.

[59] Mercy Corps, *Quick Facts: What You Need To Know About the South Sudan Crisis* (Feb. 23, 2017), https://www.mercycorps.org/articles/south-sudan/quick-facts-what-you-need-to-know-about-south-sudan-crisis.

[60] *HRW 2017* Report, at 565.

children as young as 10 who have fled there from Eritrea.[61] These unaccompanied minors face possible *refoulement* at the hands of the Sudanese government—meaning return to a country found guilty of crimes against humanity by a United Nations panel.[62]

Since conflict broke out in March 2015, almost 6,000 Yemeni people have become refugees,[63] but 18.7 million, including 10 million children, more than one-third of the total population, are in urgent need of humanitarian assistance.[64]

B. Refugee Children in the Affected Countries Experience Harmful Trauma

The level of war and violence witnessed and experienced by refugee children in these countries is extraordinary. Children in Syria have been exposed to airstrikes—including wide-area explosives, barrel bombs, cluster munitions, and flammable incendiary weapons—in their homes, markets, schools and hospitals.[65] In addition, killing and maiming of children

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[61] Women's Refugee Commission, United Nations High Comm'r for Refugees, *Young and Astray: An Assessment of Factors Driving the Movement of Unaccompanied Children and Adolescents from Eritrea into Ethiopia, Sudan and Beyond* 1 (2013).

[62] *Id.* at 2; United Nations News Centre, *Crimes against humanity committed in Eritrea, warns UN group* (June 8, 2016).

[63] *UNHCR 2015 Report*, at 67.

[64] Save the Children, *Struggling To Survive: Stories from Yemen's Collapsing Health System* 1 (2016) ("Save Yemen's Children"), https://yemen.savethechildren.net/ sites/yemen.savethechildren.net/files/library/YEM-cx-15-StrugglingTo Survive-H%26NBrief-19December2016.pdf.

[65] *HRW 2017 Report*, at 572-73.

are common along with abuse, recruitment and use by armed groups, and sexual and gender-based violence.[66] Migrants in Libya are subjected to torture, beatings, forced labor, and sexual violence.[67] In Yemen, according to one report, "[e]very ten minutes, one . . . child dies from preventable killers like diarrhea, malnutrition and respiratory tract infection."[68] Airstrikes have targeted health facilities, including hospital supply routes.[69]

A child refugee in one of these countries can expect to witness or experience violence on a daily basis. For example, plaintiff Jane Doe #2's younger nephew spent his first few months of life in a house that fighters used to fire rockets; her sister's family now lives in a house that is repeatedly subjected to shellfire from continuing warfare; and her older nephew is so accustomed to weaponry that he can recognize the type of weapon and identify what area is being targeted, from sound alone. J.A. 450. "Being a victim or witness of violent acts" or "being exposed to heavy shelling or combat," researchers have found, makes children

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[66] United Nations Children's Fund, *Syrian Conflict and Europe's Refugee Crisis in Numbers*, UNICEF Blog (Sept. 30, 2015), https://blogs.unicef.org/blog/the-syrian-conflict-and-europes-refugee-crisis-in-numbers/. The United Nations verified 2,300 offenses of such types in 2016. United Nations High Comm'r for Refugees, Syria Regional Refugee Response Inter-agency Information Sharing Portal, data.unhcr.org/syrianrefugees/regional.php.

[67] *HRW 2017 Report*, at 409.

[68] *Save Yemen's Children*, at 1.

[69] *HRW 2017 Report*, at 675-76.

"more likely to exhibit [post-traumatic stress disorder]."[70] "Those who had been exposed to bombing and combat as children were 2.3 times more likely to have severe illnesses in their early sixties," and there is a significant association between such traumas and later cardiovascular disease.[71]

Refugee camps are also violent.[72] This violence exacerbates the developmental harms from the violence that a refugee child fled in the first place. Adults living in or near a concentration of refugees may try to take advantage of their precarious situation, such as by sexually abusing children who are without parents or whose parents have little recourse to authority. Teenage refugees, cooped up in refugee settlements, are likely to become restless and violent. The resulting "unpredictable climate[] of fear" is the sort of "repetitive 'process' trauma" that can produce negative developmental effects.[73]

Many refugee children are on their own, without parents or other caregivers. Separation from parents

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[70] Werner, *supra* n.18, at 554.

[71] *Id.* at 554-55.

[72] *See, e.g.*, A. Sheehy, "Sexual Assault in the Refugee Camp," *Harvard Pol. Rev.* (Oct. 17, 2016), at http://harvardpolitics.com/hprgument-posts/sexual-assault-in-refugee-camps/; T. Gaynor, U.N. High Comm'r for Refugees, *UNHCR concerned at reports of sexual violence against refugee women and children* (Oct. 23, 2015), at http://www.unhcr.org/ news/latest/2015/10/562a3bb16/unhcr-concerned-reports-sexual-violence-against-refugee-women-children.html.

[73] Williams, *supra* n.38, at 274.

is most likely to lead to depression, and enforced separation from parents increases the likelihood of poor health in old age by a factor of 3.6.[74]

Beyond violent trauma, life in a refugee camp is unstable; refugees often struggle to find food, water, and shelter. Children are also adversely affected by the "collapse of social networks and daily routines."[75] Consider, again, the situation of the sister of plaintiff Jane Doe #2. Her children have experienced only displacement and danger for their whole lives, which they currently live out in a small motel suite of windowless, filthy rooms that are regularly exposed to artillery fire. For over a year, her husband departs every day simply searching for food and water. Now they are trapped in a cramped and unsanitary place—unable to leave because it is unsafe to do so. The children are skeptical that the sun actually comes up in the sky where they are, because they haven't witnessed it for years. The building is genuinely uninhabitable, and the family is constantly ill from exposure to human waste and to inhaled toxins. School is not available for either of the children, though as they play in their confined space they pretend to be at school. JA 450-452.

Circumstances like these constitute a psychological trauma that can "wield a severe blow to a child's sense of security and self, including central organising fantasies and meaning structures."[76] Children are developing, both neurologically and psychologically, the

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[74] Werner, *supra* n.18, at 554-55.

[75] Williams, *supra* n.38, at 264.

[76] *Id.*

ability to understand who they are and how they relate to the world. The uncertainties of life of a refugee can "effect great damage . . . because of the lingering need to re-evaluate one's view of oneself and the world."[77]

Amicus stresses that there is a dose-response relationship between the experience of trauma and stress and the occurrence of long-term health problems. This effect causes multiple forms and instances of abuse to amplify the negative impact that each has on a child's mental and physical health.[78] Even if Executive Order 13,780 were only a temporary suspension of immigration by certain Muslims, rather than a prelude to a long-term ban, that suspension would extend the exposure to trauma of many refugee children.

The health and development of these children, and thousands more just like them, will be severely disrupted by these traumas. We know that substantial healing is possible—but not so long as these children and their families are stranded in the midst of chronic, life-threatening war.

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[77] *Id.* at 268.

[78] Anda, *supra* n.16, at 176. As discussed above, scientists use the term "dose-response relationship" to mean that the impact of a deleterious substance or experience grows as the extent of exposure increases. *See, e.g., AAP Statement on Trauma*, at 3 (stating that the effects of trauma and stress "multiply when the trauma continues, whether by repetition of similar stresses . . . or accumulation of disparate ones . . . The effect may be particularly severe when trauma involves the child's primary caregiving system.").

The United States alone cannot resolve the child refugee problem. But our nation can do its part, together with the international community, to stem the tide of despair and destruction that threatens to effectively wipe out an entire generation of leaders and citizens of these six nations.

Today, Jane Doe #2's refugee nephew sits in a windowless room, listening to shells as they whistle by and explode in the border town that confines him, in the next block, in the building across the way. Tomorrow, that boy could find refuge in the United States instead—safe and free, and in sure hope of a future. The refugee children we can accept today may one day return to lead their countries out of chaos. That is the heritage and the pride of our nation.

CONCLUSION

For the reasons set forth above and those discussed in the respective briefs of the respondents, the Court should affirm the decisions of the courts of appeal.

Respectfully submitted.

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SEPTEMBER 18, 2017